Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-031

Prepared by: New York City Regional Office

Issue Date: Oct 03, 2019

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 04/04/2019
Initial Date OCFS Notified: 04/04/2019

Presenting Information

The 4/4/19 SCR report alleged that on 4/4/19, the SM and SF found the SC unresponsive in the PGM's home. The report also alleged they rushed the SC by foot to a NYC Fire Department station at 9:20 AM. The SC was then transported to the hospital via emergency services at 9:33 AM and was pronounced dead. The last time the SC was seen alert and active was at 2:00 AM. The parents had no explanation for the SC's death.

Executive Summary

The SCR registered a report regarding the death of the SC that occurred on 4/4/19. The allegations of the report were DOA/Fatality and IG of the SC by the parents. The report alleged the SC was an otherwise healthy infant and there was no plausible explanation for her death.

Following the receipt of the report, an ACS Bronx Field Office Specialist contacted FDNY, LE, EMS, and Lincoln Hospital (LH) staff to retrieve information regarding the incident. ACS learned from the FDNY staff that the SM walked into the ambulatory station at 9:25 AM, carrying the listless SC in her arms and asked for medical assistance. At 9:28, the ambulatory unit transported the SC to LH; they arrived at 9:30 AM, and the SC was pronounced at 9:49 AM.

ACS learned from the parents that the incident occurred at the PGM's home where the SF resided and the SM and SC were visiting. The PGM, PA and the parents were in the home at the time the incident occurred. The parents and the family's account of the incident were similar; however, throughout the investigation, the parents were not cooperative.

ACS learned from the PGM and PA that the SM and SC visited frequently and at times they stayed overnight. According to the parents, the SM placed the SC on top of the SM's tummy and after the SC fell asleep, she was placed between them, in the adult bed. The last time the SM saw the SC alive and alert was at 6:00 AM on 4/4/19. The parents received Safe Sleep training and opted to co-sleep with the SC, it was the practice when they were not at home. The SF disclosed that the night prior to the incident, he smoked marijuana and drank an alcoholic beverage before he returned home.

ACS learned from LH staff that the SC was found with no signs of maltreatment or abuse. EMS reported the SC was dead upon arrival to the station. The ME reported that livor mortis had begun; it was likely the SC was placed to sleep on her stomach. LE found no criminality. LH reported the parents were provided with Safe Sleep information prior to the SC's discharge from the hospital after her birth.

The parents were not known to ACS as adults and had no open service report. On 6/13/19, ACS unsubstantiated the DOA/Fatality allegation of the SC by the parents citing lack of evidence. ACS added that the ME determined the cause and manner of the SC's death was undetermined (unsafe sleep).

On 6/13/19, ACS substantiated the IG allegation of the SC by the parents citing credible evidence was found. ACS found that the parents were informed about Safe Sleep and opted to place the SC in a prone position to sleep on an adult bed with soft bedding and they failed to provide adequate sleep accommodations for the SC.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
There are no surviving siblings or other children with the parents of the SC.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/04/2019 **Time of Death:** 09:33 AM

Time of fatal incident, if different than time of death: 09:49 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 3 Hours
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	48 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	20 Year(s)

LDSS Response

On 4/4/19, ACS responded to the report registered by the SCR regarding the death of the one-month-old female SC, by contacting LH to obtain information regarding the death. According to the case documentation, the allegations were DOA/ fatality and IG of the SC by the parents as the SC was found with no indication of abuse or neglect and the parents had no explanation for the death. There were no surviving children.

On 4/4/19, ACS interviewed the SF and his family at their home where the SM and SC slept that night. The SF added that he laid the SC on her stomach because she was most comfortable; however, the SM did nothing to change the SC's sleep position for safety. She stated she awoke at approximately 9:00 AM, checked the SC and observed the SC was not breathing. The SM's screams alerted the family that something was wrong. The SF, PA and PGM attempted to administer CPR to the SC, but the SC was unresponsive. The PGM and the PA disclosed that the SC shared the bed with the parents. The PA and PGM took the SC and ran to a nearby FDNY EMS station to obtain emergency medical assistance. The family reported it took approximately ten seconds to arrive at the station.

The SM was interviewed at the MA's home and her account was similar to that of the SF and his family. The SM reported she fed the SC at 6:00 AM and placed her to sleep on her (the SM) tummy face down. She awoke to find the SC cold and unresponsive. The SM was distraught, she discontinued the interview and asked the ACS Specialist to leave the home.

ACS obtained information from the first responders, LH staff, LE, and EMS. LH staff and LE informed ACS that the family took the SC to the fire station which was in close proximity of the SF's home, at approximately 9:25 AM, on 4/4/19 to seek emergency medical assistance. The SC was given CPR and transported to LH via ambulance. They arrive at LH at approximately 09:45 AM and the SC was pronounced dead at 9:49 AM. LH staff, EMS and LE reported the SC was DOA and livor mortis had begun and that it appeared the SC had been sleeping face down. LH staff reported no injuries, marks or bruises were observed on the SC when she was brought into the LH and indicated that the SC may have passed from Cardiac Pulmonary Arrest.

LE reported to ACS that the home where the incident occurred was found in disarray with empty marijuana bags and liquor bottles. The SF admitted he was inebriated, he smoked and drank over night; it is unknown whether the SM indulged. LE found no criminality and discontinued their investigation. LH staff also reported the parents became violent and uncooperative when they were informed that the SC had died.

On 6/3/19, ACS obtained information from LH that confirmed the parents were provided Safe Sleep information prior to the SC's discharge. ACS offered bereavement counseling and services to the family and they declined all services except

to receive funeral expenses.

On 7/22/19, the Office of Chief Medical Examiner later listed the cause and manner of the SC's death undetermined (unsafe sleep).

On 6/13/19, ACS unsubstantiated the DOA/fatality of the SC by the parents due to lack of credible evidence. ACS substantiated the IG of the SC by the parents due to credible evidence. ACS documented the parents were informed of Safe Sleep and failed to provide adequate sleep accommodations for the SC at the SF's home although they had a pack and play in the SM's home. ACS added that the SF was impaired and unable or unwilling to protect the SC when they co-slept on the night of the incident.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The ACS case documentation did not reflect that there was a Multidisciplinary Team response.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: The New York City region does not currently have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051331 - Deceased Child, Female, 1 Mons	051333 - Father, Male, 20 Year(s)	Inadequate Guardianship	Substantiated
051331 - Deceased Child, Female, 1 Mons	051332 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
051331 - Deceased Child, Female, 1 Mons	051332 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated
051331 - Deceased Child, Female, 1 Mons	051333 - Father, Male, 20 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐

Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☒	☐	☐	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☒	☐	☐	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐

Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☒	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
The parents declined ACS's offer for services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

CPS - Investigative History More Than Three Years Prior to the Fatality

The parents had no CPS history as parents prior to the death of the SC.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No